## New Jersey Department of Health and Senior Services Division of Long Term Care Systems

# ASSISTED LIVING RESIDENCES AND COMPREHENSIVE PERSONAL CARE HOMES RESIDENT PROFILE REPORT

Data for Year Ending December 31, 2002, Unless Otherwise Specified

#### PLEASE REVIEW DEFINITIONS AND INSTRUCTIONS BEFORE COMPLETING FORM.

1.	FACILITY IDENTIFICATION		3. ADMISSIONS
A.	*License Number:	A.	Admissions from Home:
B.	*Facility Name:	B.	Admissions from Nursing Homes:
	*Facility Address:	C.	Admissions from Other Assisted Living/CPCH Facilities:
D.	*City:	D.	Admissions from Posidontial Hoalth Caro Escilitios
	*Zip Code:		
	County:	E.	Admissions from Acute Care Hospitals:
	Telephone No.:	F.	Admissions – Other:
	Fax No.:	G.	Total Admissions (Sum of A-F):
I.	Email Address:		4. DISCHARGES
	2. LICENSURE INFORMATION	A.	Discharges to Home:
A.	Facility Opening Date (MM/DD/YYYY):	B.	Discharges to Nursing Home:
B.	*Licensed Beds (AL/CPCH):	C.	Discharges to Other Assisted Living/CPCH:
C.	Does reported bed total in Item B represent full capacity (Y/N)?  If yes, please go to Item E.	D.	Discharges to Residential Health Care Facilities:
D.	Actual Bed Capacity (if different from Item B):	E.	Discharges While in Hospital:
E.	Administrator's Last Name:	F.	Deaths:
F.	Administrator's First Name:	G.	Discharges – Other:
	Type of Credential Held by Administrator:	Н.	Total Discharges (Sum of A-G):

\* Please list information exactly as it appears on the facility license.

5. ADL Data for Residents on 12/1/027. Chronological Data for Residents on 12/1/02

- 6. Medication Administration Data for Residents on 12/1/02
- 8. Data for Residents Discharged during Calendar Year 2002

Please use the following pages to complete Items 5 through 8.

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## 5. RESIDENTS' NEEDS FOR ASSISTANCE WITH EACH OF THE SEVEN (7) ACTIVITIES OF DAILY LIVING (ADLs) ON 12/1/02

Please do not list residents admitted after 12/1/02.

For each resident, please enter one of the following codes to identify need for assistance with each ADL:

0 - INDEPENDENT - Resident needs no assistance in perfoming the activity
1 - LIMITED - Resident needs some assistance in performing the activity

2 - TOTAL - Resident is totally dependent on others for the activity

(1) ACTIVITIES OF DAILY LIVING (ADL) (Columns 2 - 8); for definitions of each ADL, please see item 5 of instructions.							
RESIDENT ID *	DRESSING	BATHING	TOILET USE	TRANSFER	LOCOMOTION	BED MOBILITY	EATING
1	1				l .		

<sup>\*</sup> Please do not list the resident's name.

Please ask a wellness nurse to complete this portion of the survey.

<sup>\*</sup> Please use the same IDs consistently in Items 5-7.

## **Facility Name**

#### 6. RESIDENTS' NEEDS FOR ASSISTANCE WITH MEDICATION ADMINISTRATION ON 12/1/02.

Please do not list residents admitted after 12/1/02.

For each resident, please enter one of the following codes to identify need for assistance with medication administration:

- 0 Self-Administers all medications.
- 1 Requires assistance with self-administration of one or more medications.

2 - Requires administration of all medications.

		(1)	(2)		(1)	(2)
(1)	(2)	(Continued)	(Continued)		(Continued)	(Continued)
RESIDENT ID *	MEDICATION ADMIN. STATUS	RESIDENT ID *	MEDICATION ADMIN. STATUS		RESIDENT ID *	MEDICATION ADMIN. STATUS
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<sup>\*</sup> Please do not list the resident's name.

Please ask a wellness nurse to complete this portion of the survey.

<sup>\*</sup> Please use the same IDs consistently in Items 5-7.

**Facility Name** 

#### 7. CHRONOLOGICAL DATA FOR CURRENT RESIDENTS ON 12/1/02

Data for columns 1-5 are supplied by the facility; data for columns 6 and 7 will be calculated by DHSS.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
('')	(2)	(3)	(4)	(3)	(0)	(1)
	RESIDENT	RESIDENT		RESIDENT		RESIDENT
	DATE OF	DATE OF		MEDICAID	RESIDENT	LENGTH
	BIRTH	ADMISSION	RESIDENT	STATUS	AGE	OF STAY
RESIDENT ID *	(mm/dd/yyyy)	(mm/dd/yyyy)	GENDER	(Y/N?) **	IN YEARS	IN MONTHS

<sup>\*</sup> Please do not list the resident's name.

Please use the same IDs consistently in Items 5-7.

<sup>\*\*</sup> Please enter a "Y" only if the resident was actually covered by Medicaid (not on the waiting list) on the reporting date.

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## 8. DATA FOR RESIDENTS DISCHARGED DURING CALENDAR YEAR 2002

Data for columns 1-3 are supplied by the facility; data for column 4 will be calculated by DHSS.

(1)	(2)	(3)	(4)
RESIDENT ID *	RESIDENT DATE OF ADMISSION	RESIDENT DATE OF DISCHARGE (mm/dd/yyyy)	RESIDENT LENGTH OF STAY MONTHS
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<sup>\*</sup> Please do not list the resident's name.